SHARING KNOWLEDGE ABOUT DEPRESSION WITH BARBERS: A COGNITIVE REHEARSAL PROJECT UTILIZING A.D.A.A.M.-QR WEB DESIGN

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ABSTRACT

Lynwood Earl Carlton: Sharing Knowledge about Depression with Barbers: A Cognitive Rehearsal Project Utilizing A.D.A.A.M.-QR Web design.
(Under the direction of Cheryl Giscombe)

Aim: This project was implemented to assist barbers at a barbershop in Durham, North Carolina to increase confidence in sharing information about mental illness with their African American male (AA) clients. Against Depression in AA Men-Quick Response (A.D.A.A.M.-QR) provides evidence-based material about mental health, misconceptions about mental illness and community resources that are available for treatment of mental illness.

Background: Barbers are vital stakeholders in the AA community. Furthermore, barbers play an integral role in community outreach services, but they often do not have supportive resources to assist them in sharing information about mental illness with their clients.

Methodology: Barbers completed a Quick-Response (QR) code link-accessible questionnaire before the delivery of a 1-hour mental health educational module. The educational module introduced the barbers to A.D.A.A.M.-QR a web-based resource with culturally relevant mental health information for AA men. After completing the A.D.A.A.M. educational module, barbers completed a questionnaire to evaluate the effectiveness of the website. The evaluation was conducted to determine if the web design increased confidence in sharing information about mental illness in a manner that supports the enactment of change related to stigma and discussing illness in the AA community.

Results: Barbers reported that participation in the A.D.A.A.M-QR educational session: 1) increased confidence in sharing knowledge; and 2) A.D.A.A.M.-QR empowered them to share information about mental illness confidentially.

Conclusion: This education session targeted barber's confidence in sharing knowledge using A.D.A.A.M.-QR web design to increase awareness of the stigma of mental illness with AA men. Raising awareness and providing resources are the first steps to reducing the stigma of depression in the AA culture. The initial stages established a web-based design module that could be used to increase barber's confidence in sharing knowledge, and hopefully begin the conversation to bring change when discussing mental illness in the AA community.

Keywords: depression, African American, men, cognitive rehearsal technique, barbershop, barbers, stigma

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A.D.A.A.M.-QR	Against Depression in African American Men-Quick Response
AA	African American
AAM	African American Men

CHAPTER 1: THE BARBERSHOP AND AFRICAN AMERICAN MEN

The barbershop has served as a centerpiece for reaching African American (AA) men in the AA community (Fraser et al., 2009; Moore et al., 2016). Beauty salons and AA barbershops have received increasing attention as an alternative for obtaining research participation (Linnan et al., 2014; Linnan et al., 2011; Murphy et al., 2017). It is well established traditional settings have not been successful recruiting participants from the AA community. The local barbershop has served as a cultural institution that reflects the AA community and has provided an open forum for potential research numerous topics, including health interventions, health screenings and research recruitment (Moore et al., 2016; Victor et al., 2018).

Although depression is a common mental disorder, little is known about depression in AA men. Underrepresented in psychiatric research and known for having cultural distrust of providers, AA men provided limited data collection opportunities to guide mental health professionals compared to other racial/ethnic groups (Powell et al., 2019). This underserved population often present differently than the traditional signs and symptoms of depression, which has led to misdiagnosis by providers when they seek mental health care.

Depression is one of the costliest and most disabling illnesses worldwide (WHO, 2018). The World Health Organization (WHO) estimates that over 350 million people worldwide are affected by depression, leading to over 800,000 suicides each year (WHO, 2018). Major depression symptoms include memory loss, lack of focus, irritability and cognitive dysfunction, leading to substantial societal and economic costs (McIntyre et al., 2013; Probst et al., 2007). The direct cost of depression rose from approximately $173.2 billion to $210.5 billion between

2005 and 2010 (Greenberg et al., 2015), and the estimation is expected to be higher when chronic diseases related to depression are considered (Hankerson et al., 2015; Penner et al., 2010).

Individuals suffering from depression-associated symptoms are less productive at work and in their personal lives, have decreased energy, feel they receive inadequate support from supervisors, and have lower concentration when trying to perform job-related tasks (Bertilsson et al., 2013). Approximately 6-7% of AA males will develop depression in their lifetime, with more debilitating effects than other ethnic groups (Blumberg et al., 2015). The National Institute of Mental Health's Real Men, Real Depression public health campaign sought to bring greater awareness to depression in men (Rochlen et al., 2005). Despite the national attention brought to the urgent topic of mental healthcare, AA males continue to seek mental health treatment at a rate of approximately half of white males (Plowden et al., 2016).

The association between depression and suicide in other ethnic groups has been well established in the literature (Hankerson et al., 2015; Plowden et al., 2016). Women are twice as likely to be diagnosed with major depression compared to men (Walker, Salami, Carter, & Flowers, 2014), but men in the U.S. are four times more likely than women to commit suicide (Kessler et al., 2003). In 2011, the leading cause of death for AA men aged 15 to 34 was homicide, followed by accidents and suicide (CDC, 2016). Out of all AAs who died by suicide, AA males accounted for 80% of deaths in 2014. (CDC, 2016). Under the age of 12 years old, suicide rates among AA children, principally AA males, are 86% higher than Whites and Latinos (Joe et al., 2018). The U.S. Department of Health and Human Services Office of Minority Health (2016) reported that suicide rates from 1960 to 1995 increased among AA males ages 10 to 14 years of age by 233% compared to an increase of 120% among whites during the same time

period. Among AA children ages 10-19, males are 2.9 times more likely to commit suicide compared to females (CDC, 2016). Moreover, suicide remains mostly a young AA men male phenomenon (Joe et al., 2018). Unfortunately, AA men have the lowest life expectancy and the highest mortality of any other racial/ethnic group in the United States (Hankerson et al., 2015). These alarming rates of morbidity and mortality suggest that there is a need to address mental health and depression in AA men to reduce preventable chronic mental illnesses and death (Plowden et al., 2016; Valkanova et al., 2013).

Exposure to stressors, including racism and discrimination, are associated with disproportionately high rates of cardiovascular disease, cancer, HIV/AIDS, and homicide (CDC, 2016; Rich, 2000; Wayne et al., 2008). Some studies suggest Black men use maladaptive health behaviors, such as smoking, alcohol use, and poor diet, to self-manage depression and cope with the stressors of life (Kendrick et al., 2007). Researchers have also conveyed a correlation between violence, depression, and aggression with young AA males (Thomas et. al, 2015). This psychopathology of major depression and anxiety in AA men has been further described via the Environmental Affordances (EA) Model (Mezuk et al., 2013; 2010). The EA postulates contextual environmental factors provide a source of stress and opportunities to alleviate the trigger of the stress. Secondly, cultural norms and contextual factors influences how one copes with these stressors. When compared to non-Hispanic whites, AAs have a lower lifetime prevalence of major depressive disorder (Hankerson et al., 2015; Mezuk et al., 2010), but AA men have a higher prevalence and debilitating effects of depression when compared to other ethnic groups (Ward & Mengesha, 2013). Depression may be expressed differently in various ethnic groups, and the current symptom criteria may not reflect the symptoms and forms of depression in AA men (Jackson et al., 2011). Thus, reports on the prevalence of depression in

AA men may be inaccurate because current diagnostic criteria do not reflect their specific contextual life experiences (Matthews et al., 2013).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) characterizes the emotions and psychosomatic manifestations of depression (American Psychiatric Association, 2013). The numerous stressors AA men face (i.e., racial discrimination, poverty, high rates of unemployment, and encounters with the criminal justice system) should be considered when mental health providers evaluate them for depression. Some AA men do not identify with the label and conventionally defined symptoms of depression. Instead, they "chill and deal" with the stressors because these stressors are perceived as part of the typical life experience of being a black male (Kendrick et al., 2007). Questions have been raised to determine if the lower prevalence of depression in AA men is due to lower rates or misdiagnosis in this population (Keyes, 2009; Mezuk et al., 2013). Understanding the experiences and more accurate assessments of culturally-nuanced depressive symptoms in AA men may promote the development of culturally-appropriate assessment strategies and treatment interventions (Bryant et al., 2014).

African American men have a higher level of self-stigma when compared to women and white Americans (Latalova et al., 2014; Wang, 2015). African American men have a greater tendency to rely on religious beliefs for coping with mental illness. Because of this cultural perspective of strength and independence, AA men have often gravitated to more dominant masculine gender norms, such as “boys don’t cry” or “just deal with it,” which only perpetuates this self-stigmatization and limits the utilization of mental healthcare services (Kendrick et al., 2007; Vogel et al., 2011).

Due to historical experiences, AA men have a cultural distrust of mental healthcare providers (Hankerson et al., 2015). The legacy of the Tuskegee Syphilis study, commonly

referred to as the Tuskegee effect, has been preserved in the minds of AA men (Bates & Harris, 2004). Not only has this infamous study by the U.S. Public Health Service from 1932 through 1972 lead to distrust of medical providers, but it has also possibly had a profound effect on AA men participating in research studies (Bates & Harris, 2004; Hankerson et al., 2015). Inadequate psychopharmacologic research on AA men limits the information available to guide optimal medication management of mental health conditions in this population (Bailey et al., 2009). The underrepresentation of AA men in research has left providers with limited access to evidence-based strategies for successfully connecting with this population to produce better outcomes (Bailey et al., 2009).

African American men may turn to leaders in their faith-based organizations for help with their mental health conditions. In the AA community, the Black church is a sacred institution that offers numerous social, spiritual, and health benefits (Quinn, 2016). African American clergy assist with funeral arrangements, marriage counseling, christening ceremonies, and share in life's milestones. As such, they are often first-line responders to a personal crisis (Payne, 2009). In addition, AA clergy are often sought out, not only for their spiritual guidance during times of mental distress, but because their services are often free (Payne, 2014). Nearly 40% of AAs use their clergy for mental health counseling. However, less than half of the clergy have had formal training in this area of counseling (Anthony et al., 2015). Therefore, AAs who seek mental healthcare guidance from clergy may receive limited support from well-intended faith-based leaders.

1.1 Problem Statement

The alarming rates of morbidity and mortality related to depression in AA men suggest that there is a need for a more comprehensive approach to mental health in an attempt to reduce

preventable chronic illnesses and death (Plowden et al., 2016). The continued consequences of exposure to racism, depression, and discrimination are associated with disproportionately high rates of cardiovascular disease, cancer, HIV/AIDS, and homicide (CDC, 2016). Some studies suggest AA men utilize maladaptive health behaviors (smoking, alcohol use, and poor diet) to self-manage depression and cope with the stressors of life (Kendrick et al., 2007; Mezuk et al., 2013). Researchers have also conveyed a correlation between violence, depression, and aggression with young AA males (Thomas et al., 2015). When mental health professionals assess patients for the typical symptoms of depression in AA men, depression may be overlooked or misdiagnosed, and inadequate treatment may be administered (Hankerson et al., 2015). More than 80% of people suffering from the debilitating effects of depression can be successfully treated with medication, psychotherapy, or a combination of both (Anthony et al., 2015). However, implicit cultural bias has been a continuum with AA men seeking mental health care, which influenced the provision of culturally sensitive mental health care (Black et al., 2011; Hall et al., 2015; Hammond, 2012). Health care training must include cultural sensitivity training to raise awareness and reduce fears, biases, and personal stereotypes of depression in AA men (Milberg et al., 2016). A culturally-sensitive, therapeutic alliance is required to preserve AA men's prioritization of masculinity, as well as his life experience of exposures to prejudices and racism (Suite et al., 2007). Failure to acknowledge these biases will only continue to expand the mental health disparities between AA men and other ethnic minorities and white Americans.

1.2 Purpose of the Project

The Doctor of Nursing Practice (DNP) project was a barber-centered intervention to increase confidence in knowledge sharing about depression with their AA male cliental through cognitive rehearsal utilizing a novel web-based educational module called Against Depression in

African American Men-Quick Response (A.D.A.A.M-QR). This work was grounded on the premise of underutilization of mental health care in AA men due to stigma and fear of AA community perceptions. The QR code link allowed the information to be disseminated in a manner that protected privacy of participants. The first goal of this project was to empower barbers with supportive materials that increase confidence when discussing mental health with their AA male clients. The second goal of this project was to provide access to a web-based module that provided barbers basic, yet helpful, knowledge about mental illness.

CHAPTER 2: REVIEW OF LITERATURE ON BARBERSHOP INVENTION

To determine if implementing a barbershop-based intervention was appropriate, the project director conducted a literature search using relevant search terms by means of three major electronic databases: PubMed, Psych INFO, and CINAHL. The search was limited to articles about interventions in barbershops directed towards AA barbers. The search terms used were: barbershops, barber, African American men, health promotion, and mental health. The inclusion criteria entered in combination are English language, published from 2009 to 2018, the age range of participants greater than 18-years-old, and focused on African American, black male, mental health, depression, barbers, barbershop, or interventions for health disparities. Exclusion criteria were unpublished dissertations, AA women, and salons. The same combinations and search terms were used for each database. The literature search yielded 242 articles that were reviewed for relevance by examining titles and abstracts. After review, 229 articles were omitted for failing to meet criteria because they were dissertations, book chapters, or not meeting inclusion criteria (Figure 1). The 13 studies included were identified and published in the USA from 2009 to 2018. Two were randomized control trials, one qualitative systematic review, one literature synthesis, four quasi-experimental studies, four cross-sectional surveys, and one pilot study (Luque et al., 2011).

Barber-based interventions have been utilized to deliver health messages to AA men in barbershops. The most prevalent topics based on the literature synthesis were: cancer, blood pressure control, diabetes, kidney/cardiovascular disease, nutrition and physical activity, smoking, stroke, organ donation, and general health (Linnan et al., 2014). Two studies used

customized educational materials to promote knowledge and awareness of prostate cancer for barbers (i.e., Fraser et al., 2009; Luque et al., 2011). Three studies focused on hypertension control using the barbershop (i.e., Rader et al., 2013; Victor et al., 2009; 2011; 2018). Two randomized control studies consisted of hypertension interventions that was delivered by barbers. The studies consisted of blood pressure messaging by the barber including model stories, referral to healthcare providers, partnering with pharmacists for medication management, and distributing educational pamphlets (Victor et al., 2011, 2018).

One study used barbershop-based interventions to promote physical activity and decrease crucial other risk factors for African American men (i.e., Hood et al., 2015). Three additional studies evaluated barbers/barbershops as key stakeholders for interventions that provided health promotion, health screenings, physical activity and research participation for AA men (i.e., Hood et al., 2018; Linnan et al., 2014; Moore et al., 2016). Lastly, one systematic review concluded that in addition to barber administered interventions, additional studies focused on surveying or interviewing barbers to assess for feasibility in future interventions (Luque et al., 2014).

2.1 Barbershop Interventions Outcomes

In these 13 studies, barber delivered interventions were effective in changing customer behavior when combined with research-developed information. Blood pressure interventions led by barbers encouraging clients to meet with specialty-trained pharmacist that were prescribers in barbershops led to an increase in blood pressure control at a 10-month follow-up assessment compared to the control group that consisted of barbers encouraging lifestyle changes and attending scheduled doctor appointments (Victor et al., 2011, 2018). Hypertension improvement was observed in systolic BP declined from 17 to 25 mmHg. Similar hypertensive reduction results were achieved among 63.6% of AA men in the intervention group compared to 11.7% in the comparison group (Rader et al., 2013). Three studies showed significant increases in

barbershop client's prostate health knowledge and the likelihood of discussing it with a health care provider (Fraser et al., 2009; Luque et al., 2011). One study had a significant increase in fruit and vegetable consumption from baseline to the eight-month follow-up (Hood et al., 2015). The primary theme of trust when AA men were choosing a provider for health education and screenings (Hood et al., 2012; Moore et al., 2016). Lastly, AA barbershop remain key stakeholders in health promotion. Barbers reported a personal commitment and obligation to the AA community and valued being a voice of support (Hood et al., 2018; Murphy et al., 2017).

From this systematic review of the literature, four random control trials (RCT) and two literature reviews were identified. The RCTs were higher-quality studies with cluster randomization to avoid between-group contamination and facilitated blinding. They included rigorous statistical analysis (Victor et al., 2011, 2018). Other studies were underpowered with small sample sizes or lacked statistical analysis. Five studies showed improvements in health promotion and clinical outcomes with barber-based interventions (Linnan et al., 2014; Luque et al., 2010; Murphy et al., 2017; Victor et al., 2011, 2018). The current review suggests the potential promise of implementing a barber-based education intervention to increase confidence among barbers in educational discussions with AA male clients about mental health.

2.2 Conceptual Model and Framework

African American males seek mental health treatment at a rate of approximately half that of white males (Plowden et al., 2016). To successfully engage AA men in therapy, culturally relevant, community-based, and culturally trusted strategies must be implemented. According to Bronfenbrenner's (1977) Ecological Systems Theory (EST), an individual's psychological development throughout their lifespan is influenced by five multisystem layers of the environment (Eriksson et al., 2018). At the core of the EST, the environment is defined as any event or condition outside of the individual that affects or is affected by the person's

development. The EST provides a framework that gives insight into the contextual factors that influence the psychological development of AA men (Appendix B). These environmental factors have influenced attitudes about discussing mental health care or seeking treatment from a mental health professional.

Ecological Systems Theory includes a conceptualization of the environment with five levels: microsystem, mesosystem, exosystem, macrosystem, and chronosystem environments (Bronfenbrenner, 1977). The microsystem characterizes intimate relationships as the primary influencer for AA males, followed closely by peers and social groups. Through these relationships, AA men develop beliefs that mental health is a weakness (Hammond, 2012). There is an underlying assumption that if depression is not discussed, then the problem does not exist.

African American men have taken a masculine role by society, as a concept referred to as "John Henryism," which may affect thoughts, feelings, and behaviors (Hammond, 2012; Plowden et al., 2016). John Henry has been used as a metaphor to describe the struggle of African American men in the community (Plowden et al., 2016). Though John Henry's perseverance and physical strength enabled him to out-perform a technologically advanced machine, he died of physical and emotional exhaustion after creating a tunnel through stone. This can be paralleled with the life experiences of AA men (James, 1994). The effect of environmental stressors creates significant and burdensome mental and physical demands in the context of inadequate coping resources, which leads to a depletion of biopsychosocial resources and depression, heart disease, and premature mortality in AA males (Matthews et al., 2013; Plowden et al., 2016).

The second level of the EST, or the mesosystem, has a broader influence on the AA male in their local community (Bronfenbrenner, 1977). As an extension of the microsystem, there is a social and self-stigma in the local AA community when discussing mental health. African

American males have higher levels of self-stigma concerning mental health when compared to women and Caucasians (Latalova et al., 2014). Churches, schools, barbershops, and other community entities influence African American males attitude regarding seeking mental health treatment and they rely on religious beliefs to cope with mental illness (Hankerson et al., 2015).

The literature proposed seeking mental health care may be a sign of a lack of faith or trust in God. Emotional detachment caused by attempts to cope may cause AA males to ignore or minimize feelings or symptoms associated with depression or mental illness (Kendrick et al., 2007). Although research has shown positive associations between religious coping and mental well-being, negative religious attitudes about mental health can lead to poorer mental health outcomes (Weber & Pargament, 2014). According to Weber and Pargament (2014), a negative religious struggle is associated with worse anxiety, as well as an increase in suicidal ideation. Self-silencing and underutilization of available mental healthcare in the face of perceived stigma and culturally inappropriate care, may exacerbate the deleterious effects of emotional distress in this population.

The exosystem is the third environment of the EST, and encompasses elements of the microsystem that affect AA men indirectly (Bronfenbrenner, 1977. Due to the limited resources available in the AA community, local government agencies and other community resources present a challenge for accessing appropriate mental health care for AAs. (Bates & Harris, 2004; Hankerson et al., 2015). Limited socioeconomic mobility, compromised opportunities for academic achievements, educational success and substandard living conditions all affect mental health (Plowden et al., 2016). In addition, many providers have subconscious stereotypes, or implicit bias, about AA males that impair their ability to make accurate assessments for depression and administration of proper treatment when compared to whites (Penner et al., 2010).

The fourth environment of EST is the macrosystem, which encompasses the cultural ideologies and beliefs (i.e., social norms, behaviors, and beliefs), as well as political systems and laws that influence an individual's life development (Bronfenbrenner, 1977). There is a correlation between joblessness, discrimination, poverty, gun violence and major depression over the lifetime of AA males (Plowden et al., 2016). Homelessness is also directly linked to an increase in mental health problems and incarceration with AA men.

In the fifth environment, the chronosystem represents the transitions or changes that occur during an individual's life, such as marriage and divorce (Rosa & Tudge, 2013). Although these developmental transitions are inevitable despite race/ethnicity or gender, they may be additive challenges in the lives of AA males who face various other stressors and challenges. Each of the five environmental levels in the EST shaped the current mental health crisis affecting AA males.

The primary focus of this project was the mesosystem environment. This environment refers to the connections between various personal experiences of school, family, and church that have influenced the AA male's perspective on seeking mental health (Bronfenbrenner, 1977). Stigma from family, as well as social and self-stigma have created barriers for AA males seeking support (Sirey et al., 2014). The focus of this barbershop-based intervention is to influence the beliefs and behaviors of the barber through increased knowledge about mental illness.

CHAPTER 3: DOCTOR OF NURSING PRACTICE METHODOLOGY

There is evidence for the value of educational resources for barbers and an educational web design module to raise awareness about mental illness and its stigma in the AA community (Linnan et al., 2001; Murphy et al., 2017). By raising awareness about resources for mental health and the detrimental outcomes of emotional distress among AA men, barbers can gain skills and knowledge to address this problem and enact change. A.D.A.A.M.-QR is an evidenced based web module that is a culturally tailored to increase a barber's confidence in sharing knowledge about mental illness with their clientele (Appendix A).

3.1 Design

This DNP is a feasibility study that provided cognitive rehearsal training for increased sharing of knowledge about mental health. Barbers evaluated the web-design education session to determine its potential to increase confidence in knowledge with AA clients. The project director submitted the DNP project Reference ID 245798, to the Office of Human Research Ethics, which determined that this submission does not constitute human subjects research as defined under federal regulations [45 CFR 46.102 (d or f) and 21 CFR 56.102(c)(e)(l)]. The final determination is that this project did not require IRB approval.

3.2 Setting

The Renaissance Barbershop is located in suburban Durham, North Carolina, in a suburban shopping area. The barbershop provides services to over 300 clients weekly and has ten barbers on staff. Though the customer base is predominantly AA men, multiple ethnicities and various sexes are served by the barbershop.

3.3 Key Stakeholders/Program Participants

The key stakeholders for the project were the barbers. The researcher first sought support of the barbershop owner for this project by presenting information about the proposed DNP project at one of our introductory meetings. The barbershop owner expressed interest in hosting and encouraged his barbers to participate in the evidence-based web design A.D.A.A.M-QR project. The project director provided sandwiches and drinks to all participants after the didactic session as an expression of gratitude for their participation. The project director conducted one one-hour session that was attended by eight barbers.

The participants in the cognitive rehearsal educational session were staff barbers. The barbers attended a one-hour session, which included reviewing the A.D.A.A.M.-QR educational module and evaluating its effectiveness. The project director delivered this content. Barbers who participated in the sessions completed a post-presentation evaluation of the website. The educational session evaluation did not require personal data from the participants. To protect the privacy of the barbers, the educational module evaluation did not include information about the barbers who attended, nor was any monetary incentive offered or given for participation in the sessions.

3.4 Procedure for Project Implementation

The project director asked the barbers to attend a one-hour session that had two evaluation components: 1) a pre-education assessment to evaluate current barber's perceptions of mental illness; and (2) an evaluation of the information presented by the web design. In Part I of the pre-education assessment, the project director gave participants access to the web-based module by scanning a quick-response (QR) code using their personal cell phone. If barbers did not have the application on their phones to access QR code materials, they were taught how to

download the application by the project director. The barbers were asked to answer true or false to the ten questions listed below (Appendix C):

1. I feel comfortable discussing mental illness.
2. Depression is not that serious.
3. Depression is a sign of weakness.
4. Depression is a sign of not trusting God.
5. Depression is used by the white man as a way to hold a black man down.
6. Most of the time, you can ‘shake’ depression without medication.
7. When African American men feel 'down and out,' they don't talk about it.
8. A sign of depression includes feeling a lack of energy to get out of bed.
9. Most African American men are willing to take medication for depression.
10. Many African American men would feel ashamed if anyone knew they had depression or mental illness.

Part II of the educational session was comprised of A.D.A.A.M-QR education session in which the project director provided instruction on navigating the module and introduced the following items via the website on their personal phones:

1. explanation of A.D.A.A.M.-QR;
2. definition of mental illness;
3. myths about depression;
4. mental illness explained;
5. startling statistics about AA men and mental illness explained;
6. understanding depression & depression;
7. treatments for depression;

8. understanding mental health hygiene;
9. community resources available to assist with mental health; and
10. questionnaire and evaluation of A.D.A.A.M.-QR.

The one-hour training session on A.D.A.A.M-QR and cognitive rehearsal took place at the Renaissance Barbershop during the lunch hour. The project director allowed the barbers to have access to the website as support for sharing information about mental illness with their clients. Mental health scenarios were presented, and the barbers accessed A.D.A.A.M.-QR to practice giving appropriate responses to their clients over the cultural stigma-based perspectives.

3.5 Project Evaluation

At the end of the educational module, participants were asked to complete an online evaluation with ten questions about the educational session (Appendix D). The assessment was administered online using the Survey Monkey website. Descriptive statistics were utilized to summarize the barbers' feedback. This process was used to determine if the web-based A.D.A.A.M.-QR educational module was beneficial in increasing knowledge about mental health with their clients and to obtain information about how the current version of A.D.A.A.M.QR may be revised based on barber feedback for future implementation of the module with barbers.

CHAPTER 4: RESULTS AND EDUCATION PROGRAM EVALUATION

The aim of this project was to pilot and evaluate a web-based educational module that can be implemented to enhance the barbers' confidence in sharing knowledge about depression with their clients to reduce the stigma of mental illness. The one-hour session included two components: 1) presentation of web-based educational module; and 2) evaluation of the educational module content. The impact of this educational module was assessed using content analysis of participants' (N =7) responses to personal assessment questions that were asked prior to engaging with the web-based educational module.

Seven barbers completed Part I of the pre-session evaluation (Appendix D). The majority of barbers (85.7%; N=6) reported they were comfortable discussing mental illness with their AA male clients.

Table 1

Barber's Pre-Session Responses

Question	Barbers	Agree	Disagree
I feel comfortable discussing mental illness.	7	86%	14%
Depression is not that serious.	7	0%	100%
Depression is a sign of not trusting God	7	0%	100%
Depression is used by the white man as a way to keep black man down.	7	29%	71%
Most of the time you can 'shake' depression without medication.	7	29%	71%
When AA men feel 'down and out' they don't talk about it.	7	86%	14%
A sign of depression includes feeling a lack of energy to get out of bed	7	100%	0%
Most AA men are willing to take medication for depression	7	0%	100%
Many AA men would feel ashamed if anyone knew they had depression.	7	100%	0%

One hundred percent of the barbers reported AA men would feel ashamed if anyone knew they had depression or mental illness. Five out of seven (71.43%) barbers said depression could not be 'shaken' without medication. The same number of barbers reported depression was not used as a way of keeping black men down. Based on the initial screening of the barbers, they appeared to have knowledge of the mental illness and did not seem to carry the stigma that had been represented in the literature. All the barbers agreed they can recognize the usual signs of depression and that AA men would not be willing to take medication for depression. Each barber also agreed depression was not a sign of distrusting God.

After Part II of the education session was completed, a web-based evaluation powered by survey monkey was conducted to evaluate the effectiveness of using ADAAM-QR to increase confidence in knowledge sharing. On the post-evaluation survey, all of the participants (N=8) agreed the content of the web-based training was interesting.

Table 2

Barber post-A.D.A.A.M.-QR responses

Question	Barbers	Strongly Agree	Agree	Agree or Disagree	Disagree	Strongly Disagree
The content on depression was interesting.	8	100%	-	-	-	-
The education session increased my knowledge about mental health	8	63%	38%	-	-	-
The education session increased my knowledge about depression.	8	50%	50%	-	-	-
The education session increased my knowledge about potential effects of depression.	8	63%	25%	12%	-	-
The education session increased my confidence in sharing about depression with my customers.	8	88%	12%	-	-	-
Using the rapid response code gave me a great sense of privacy and respect.	8	63%	25%	12%	-	-
The session was held in a setting that was convenient.	8	88%	12%	-	-	-
The content was well organized	8	75%	25%	-	-	-
The education materials (website) are potentially useful.	8	88%	12%	-	-	-

Sixty-three percent (N=5) strongly agreed and 37% agreed (N=3) the web-based educational session increased their knowledge about mental health. Eighty-eight percent (N=7) strongly agreed,

and 13% agreed the education session increased their confidence in knowledge sharing about with their customers, and the mental health education materials on the A.D.A.AMQR website are potentially useful. Fifty percent (N=4) strongly agreed and agreed (N=4) the education session increased their knowledge about behaviors associated with depression.

The barbers expressed having a web-based educational tool gave them support and materials to serve their customers better. Sixty-three percent of the participants felt utilizing the web-based design provided the customers' privacy to read about the stigma of mental health and locate community resources in a convenient, discreet manner. The barbers expressed this would be beneficial to other barbers and barbershops nationwide. However, they revealed one hour was not enough time for them to get the full benefit from this type of unique training. Another barber requested alternative treatments (i.e., natural herbs) for depression. Another commented on having additional information on the website concerning discreetly sharing web-based information with clients. Many African American men would feel ashamed if anyone knew they had depression or mental illness. One hundred percent (N=8) of the participants agreed the content of the web-based training was interesting. Sixty-two percent (N=5) strongly agreed and thirty-eight percent (N=3) of the participants said the web-based educational module increased their knowledge about mental health. Eighty-eight percent (N=7) strongly agreed and thirteen percent agreed the educational module increased their confidence in knowledge sharing with their customers. Fifty percent (N=4) strongly agreed and agreed (N=4) the education session increased their knowledge about behaviors associated with depression.

The barbers conveyed having a web-based educational module gave them support and materials to serve their customers better. Sixty-three percent felt utilizing the web-based design provided the customers privacy to read about the stigma of mental health and ability to local community resources in a convenient, discreet manner. The barbers expressed this would be beneficial to other barbers and barbershops nationwide. However, they revealed one hour was not enough time for them to get the full benefit from this type of unique training. Another barber requested alternatives to medication for depression. Another commented on having additional information on discreetly sharing web-based information with clients.

4.1 Barber's Perspective on A.D.A.A.M.-QR

The primary focus of this quality improvement project was to increase confidence in knowledge sharing about mental illness with AA clients utilizing barbers as lay mental health advocates. This project focused on education via cognitive rehearsal using a web-based design with the ultimate aim of increasing confidence in knowledge sharing, eventually dismantling the stigma of seeking mental health assistance with AA men. The one-hour educational module on mental health can be used to provide support for barbers when discussing mental health with their AA male clients.

The participants overwhelmingly liked the web-based educational module. In addition, they fancied they could provide comments and offer suggestions to A.D.A.A.M.-QR for future revisions. The barber's reported A.D.A.A.M.-QR provided them a practical resource that could be shared with their clients and did not feel intrusive or compromise client confidentiality. The participants requested additional sessions for the opportunity to include more barbers. The participants recommended linking A.D.A.A.M.-QR to social media for dissemination of the cultural focus on mental health educational content.

4.2 Unexpected findings

Participants shared personal experiences with seeking mental health counseling. The barbershop owner voiced he was seeing a therapist to be the “best man” he could be. He encouraged other barbers to pursue the same assistance. Another barber shared he had spent time in a state hospital after having a breakdown due to personal reasons. He stated the educational module resonated loudly with him. Another barber reported he had a client that repeatedly said, “I can't take this anymore." The barber stated he did not think it was that serious. The next day, he learned the client walked out in front of a speeding truck and completed suicide. The Barbershop owner posted on Facebook and Twitter:

We had a great workshop today learning and participating in a feasibility study on Mental Health and the role of the Barbershop with a focus on African American men…As barbers, being armed with the knowledge and tools to point a client in the right direction in the time of need, oftentimes, is the difference between life and death. We, as a community, have to get to the place where we embrace our mental health just as we do our physical, emotional, and spiritual health. Personally, therapy has been transformative for me. The better [I] can be, directly contributes to being better Dad, entrepreneur, friend and everything else.

Following the educational module with A.D.A.A.M.-QR, the project director was invited to participate in “No Shades November: A Barbershop Chat About Black Men’s Mental Health” at Renaissance Barbershop. There were approximately 25 AA men in attendance that shared experiences with various stressors they had faced. Over 400 views and 38 discussion posts occurred during the Facebook Live format of this discussion of mental health and AA men.

CHAPTER 5: DISCUSSION

The primary focus of this DNP project was to increase confidence among barbers in sharing knowledge about mental illness with AA clients, to aid in dismantling the stigma of seeking mental health assistance. The barbers overwhelmingly liked the web-based educational session. The barbers were pleased they could comment and make adjustments to address their concerns. The barber's reported A.D.A.A.M.-QR provided them a practical resource that could be shared with their clients, and did not feel intrusive or compromise client confidentiality. The participants requested additional sessions for more barbers to be involved. The participants recommended A.D.A.A.M.-QR should be linked to social media for dissemination of the cultural focus on mental health educational content.

5.1 Barriers to Optimal Implementation

Barbers and barbershops have participated in various health improvements, health screenings, and blood pressure monitoring for AA males (Linnan et al., 2001; Murphy et al., 2017). Mental health challenges are complex and they are crippling the AA male community. Community barbers may play an integral part in sharing knowledge about the stigma of mental illness and community resources that are available to serve clients that are in need. The cultural and historical experience of the AA community with regard to participation in research may have constrained the implementation of the proposed project. Therefore, barbershop management support was critical to the success of the implementation of a web design project. The researcher secured support and endorsement of the barbershop owner.

The AA male perception that depression is a “part of life” and to just “deal with it” (Hammond, 2012; Plowden et al., 2016) may have been potential barriers to the implementation of this project and to barbers’ and their clients’ ability to understand the dynamics of mental illness. Barbers may not have chosen to participate in the proposed project's educational session due to distrust that stemmed from the previous exposure of AA men to racism, discrimination, and bias in scientific explorations (e.g., the Tuskegee effect; Bates & Harris, 2004). The project director was concerned about distrust related to the educational session because of affiliation with a predominantly white educational institution, which may have prevented the barbers from participating in the project. The project director thus obtained buy-in from the barbershop owner to ensure the implementation of the project.

Furthermore, concerns over cyber-security may have been a barrier. The barbers were using their personal devices to access the website using the QR-code reader. Concerns with collecting personal information from their phone may have influenced participation. In addition, limitations to using the phone features may have been a challenge to implementation. Buy-in from the shop owner provided confidence for personal cellphone use to conduct the education session and evaluation of the sessions. The project director made several visits to the barbershop prior to implementation to build a rapport with the champion and participants who desired to improve outcomes in AA men that struggle with mental illness.

Another potential barrier to the implementation of the proposed project was the sensitive content of discussing mental health with AA men. The project director gathered the support of the barbershop owner at the outset of the project and kept him informed about the progress of the project. The buy-in of the champion was critical to the implementation of the project; his support influenced the barbers’ participation in the educational session and their completion of the post evaluation survey.

5.2 Strengths of the Proposed Project

The strength of this proposed project was a web-based educational module that was culturally designed for AA men. Although barbers have often been the source of various community outreach efforts, they have been equipped with resources to increase confidence in knowledge sharing about mental health. Thus, designing this web-based design with cultural sensitivity and discretion was a beneficial concept. The project director talked with the barbershop owner and was able to draw from a wealth of knowledge about these clients, which were strengths of this project. The web design focused on the cultural enigma related to seeking mental health and stigma associated with mental illness. The QR-code was linked to A.D.A.A.M. to provide privacy for knowledge sharing. The website allows user feedback for continued improvements for future use by barbers.

5.3 Potential Weakness of the Proposed Project

Potential weaknesses of the project include the fact that the educational session was delivered in a 60-minute time frame. The information had to be condensed for barbers that have minimal to no knowledge of mental health and presented in a limited time. In addition, the Renaissance Barbershop is located in a suburban area of Durham, North Carolina. The initial opinion questionnaire that was given prior to the educational session may be viewed differently if the educational session was presented in a more rural or urban area.

The focus of this project was to pilot and evaluate a web-based educational session that can be implemented for quality improvement purposes by enhancing barbers' confidence in sharing knowledge with their clients to reduce the stigma of mental illness. The project included two parts: a web-based educational session on increasing confidence in knowledge sharing with

AA barbers as lay mental health advocates and evaluation of the educational session's content, eight barbers working in an urban barbershop in Durham, North Carolina.

5.4 Conclusions and Recommendations

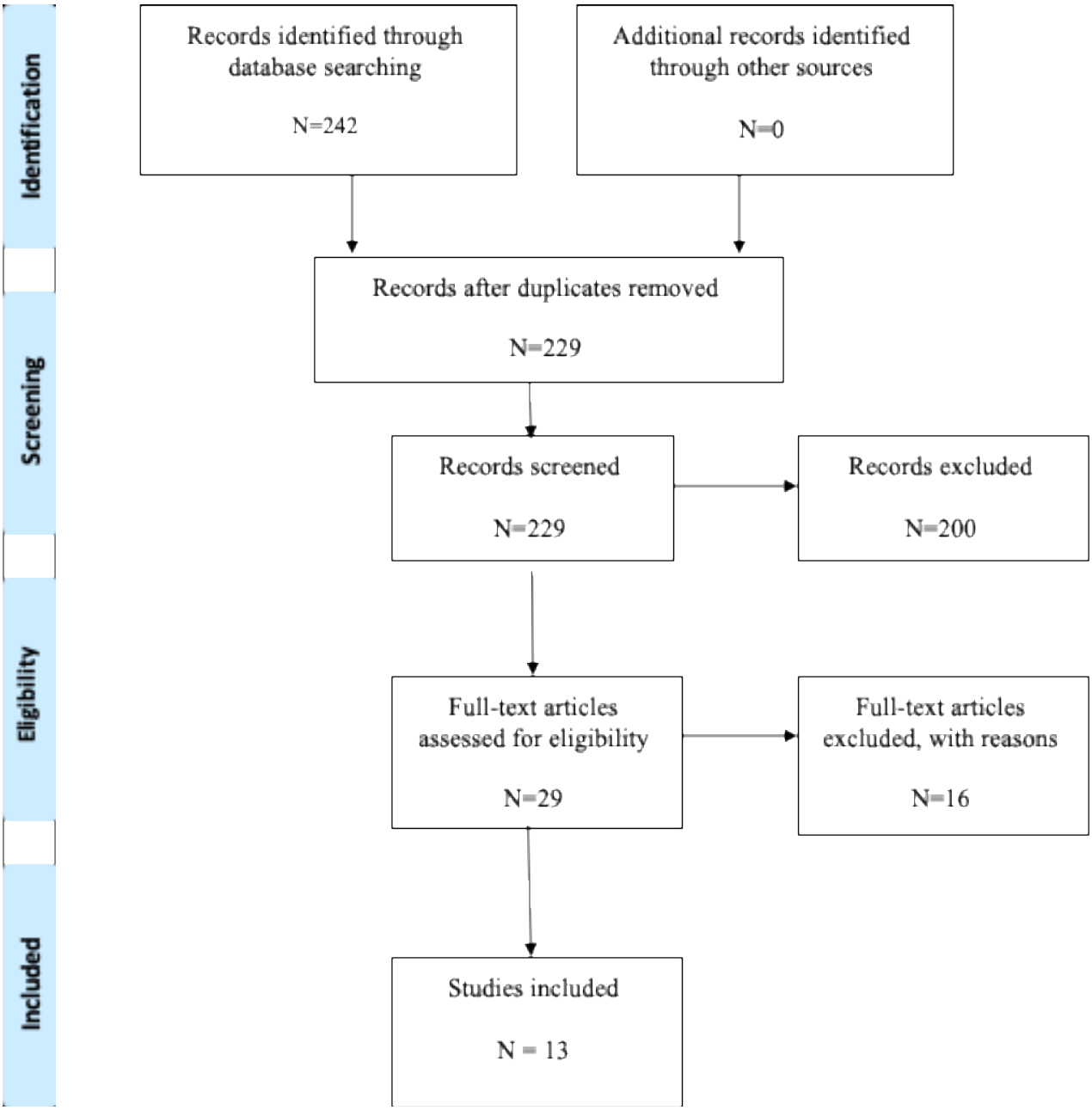
The barbershop is a meeting place where information is disseminated in the community among AA men. On Saturday's, barbers were the preachers behind the chair. Many myths and stigmas exist concerning mental health in the AA community. To enact change, a cultural understanding of spirituality and trust must be considered. The barber is established and well-known in the AA community; therefore, they are key stakeholders. A.D.A.A.M was a web-based design to empower barbers to share information with their clients, but also to empower the barber with confidence and evidence-based knowledge.

The conversations were boisterous and insightful. After haircuts were completed, hours would be spent congregating and sharing the latest news from the previous week. Given the sparse representation of AA men in literature, a more creative approach is needed to reach this underserved population. This project represented the need to target AA men where they congregate and disseminate information. Since AA men are less likely than other groups to volunteer to come to clinics or participate in research, their voice is inadequately represented. African American men have experiences that are unique to their culture, and thus to be effective, we must meet them in the locale where they are safe and trust the information provided. Barbers recognize they have a responsibility when it comes to the AA community, and those who participated in this project desired to be equipped with information they could to share with their clients.

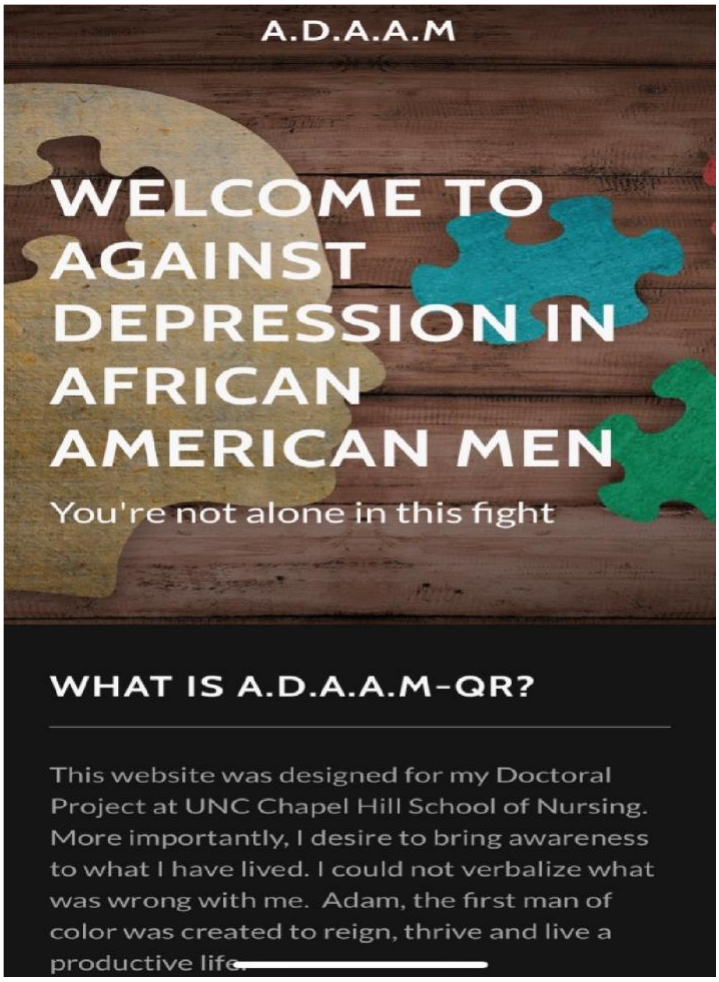
Against Depression in African American Men-Quick Response is module that can be amended to be applied in different settings regardless whether it is an urban or rural barber.

Feedback from the barbers gave the project director a greater awareness of the importance of cultural competence and ethnic awareness when addressing the sensitive nature of mental illness. Future recommendations would be an education session with barbers on how to access and share QR codes with clients to ensure discreet sharing on accessing the module. Another recommendation would list community resources to help clients that recognize they may have the symptoms of mental illness after reviewing the information on A.D.A.A.M. Lastly, more information on medications should be included. There are myths concerning medications and alternative treatments for depression that needs to be addressed in a sensitive, but accurate manner. This DNP project has shown A.D.A.A.M.-QR increases a barber's confidence in sharing knowledge to promote mental health among AA men and the AA community as a whole.

APPENDIX 1: PRISMA FLOW DIAGRAM

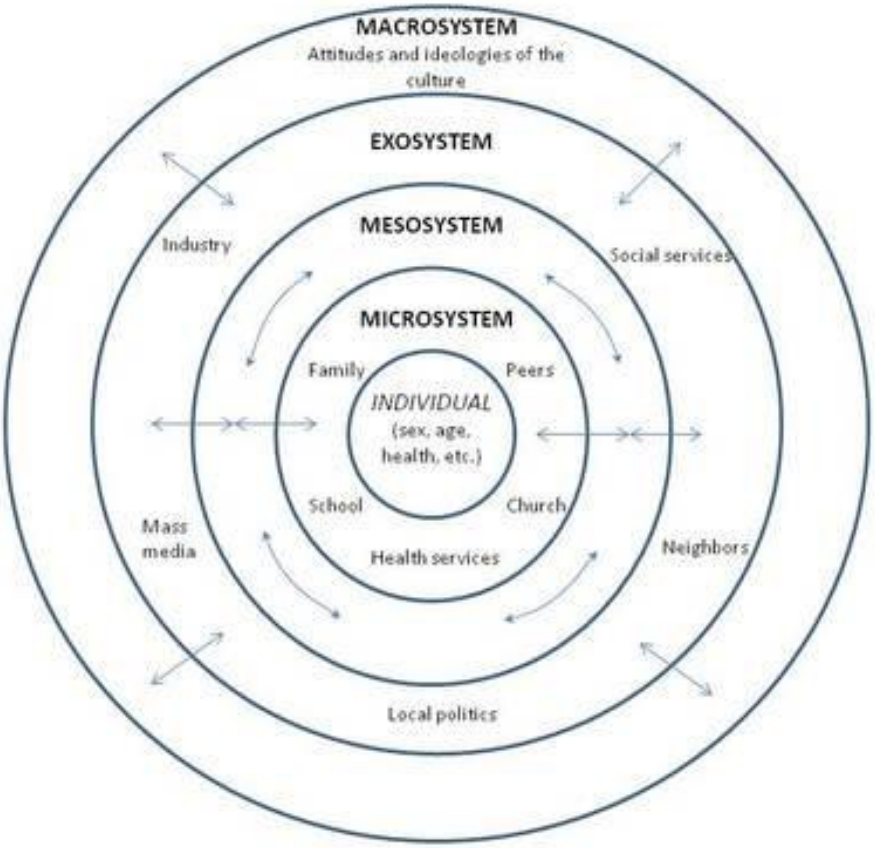


APPENDIX 2: AGAINST DEPRESSION IN AFRICAN AMERICAN MEN – QR



APPENDIX 3: BRONFENBRENNER'S ECOLOGICAL SYSTEMS THEORY (EST)

(Eriksson, Ghazinour, & Hammarström, 2018)



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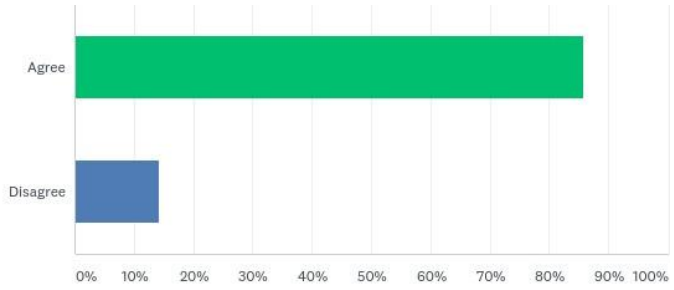
APPENDIX 4: PRE-EDUCATION QUESTIONAIRE

Q1: I feel comfortable discussing mental illness.

Answered: 7 Skipped: 0



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Q1: I feel comfortable discussing mental illness.

Answered: 7 Skipped: 0

ANSWER CHOICES	RESPONSES	
Agree	85.71%	6
Disagree	14.29%	1
TOTAL		7

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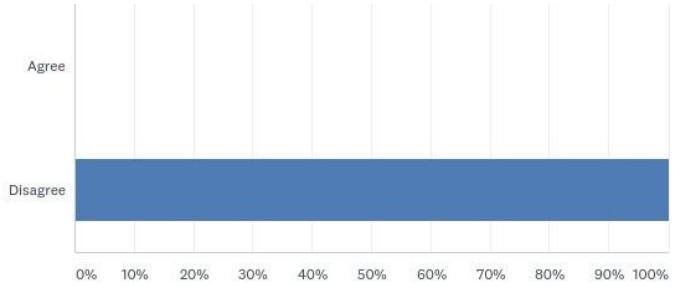
Q2: Depression is not that serious.

Answered: 7 Skipped: 0



Powered by SurveyMonkey

Q2: Depression is not that serious.

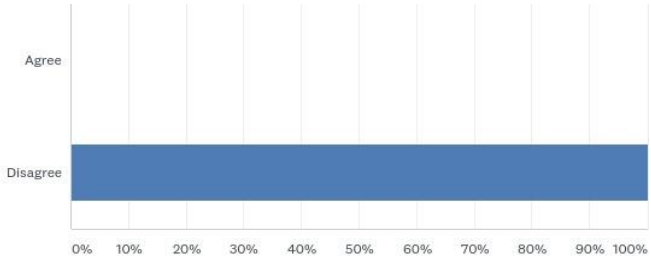
Answered: 7 Skipped: 0

Powered by SurveyMonkey

ANSWER CHOICES	RESPONSES	
Agree	0.00%	0
Disagree	100.00%	7
TOTAL		7

Q3: Depression is a sign of weakness.

Answered: 7 Skipped: 0



Powered by SurveyMonkey

Q3: Depression is a sign of weakness.

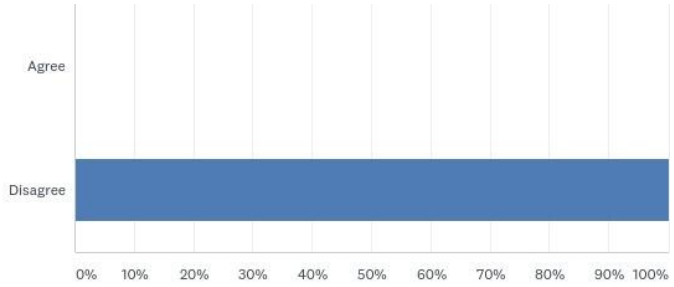
Answered: 7 Skipped: 0

ANSWER CHOICES	RESPONSES	
Agree	0.00%	0
Disagree	100.00%	7
TOTAL		7

Powered by SurveyMonkey

Q4: Depression is a sign of not trusting God.

Answered: 7 Skipped: 0



Powered by SurveyMonkey

Q4: Depression is a sign of not trusting God.

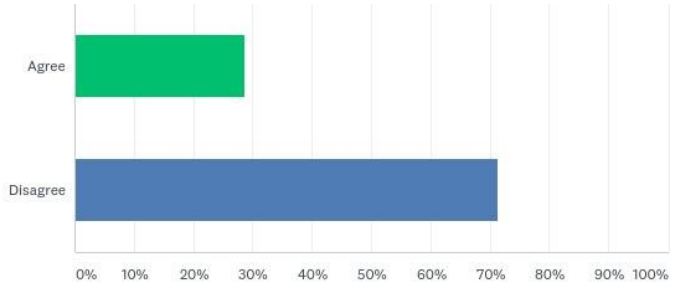
Answered: 7 Skipped: 0

ANSWER CHOICES	RESPONSES	
Agree	0.00%	0
Disagree	100.00%	7
TOTAL		7

Powered by SurveyMonkey

Q5: Depression is used by the white man as a way to hold a black man down.

Answered: 7 Skipped: 0



Powered by SurveyMonkey

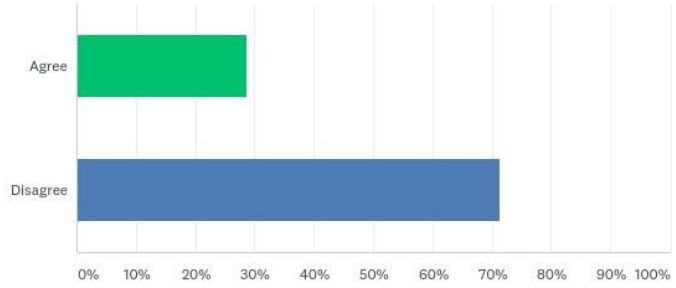
Q5: Depression is used by the white man as a way to hold a black man down.

Answered: 7 Skipped: 0

ANSWER CHOICES	RESPONSES	
Agree	28.57%	2
Disagree	71.43%	5
TOTAL		7

Q6: Most of the time you can 'shake' depression without medication

Answered: 7 Skipped: 0



Powered by SurveyMonkey

Q6: Most of the time you can 'shake' depression without medication

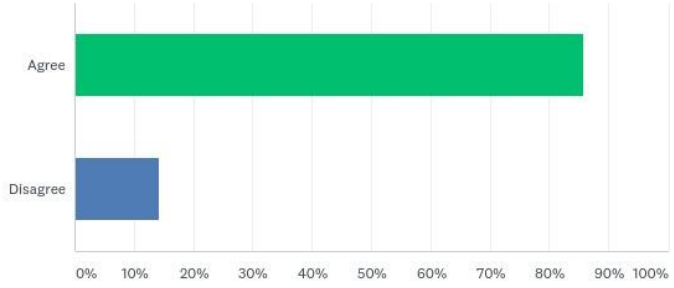
Answered: 7 Skipped: 0

ANSWER CHOICES	RESPONSES	
Agree	28.57%	2
Disagree	71.43%	5
TOTAL		7

Powered by SurveyMonkey

Q7: When African American men feel ‘down and out’ they don’t talk about it.

Answered: 7 Skipped: 0



Powered by SurveyMonkey

Q7: When African American men feel ‘down and out’ they don’t talk about it.

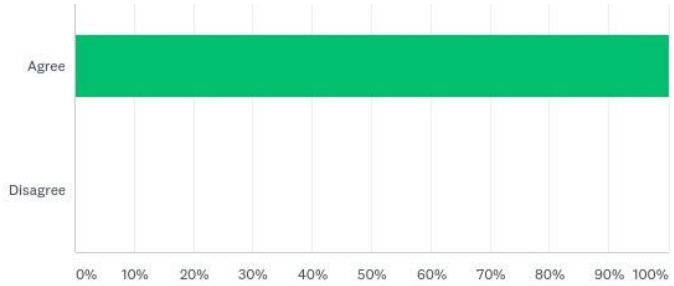
Answered: 7 Skipped: 0

ANSWER CHOICES	RESPONSES	
Agree	85.71%	6
Disagree	14.29%	1
TOTAL		7

Powered by SurveyMonkey

Q8: A sign of depression includes feeling a lack of energy to get out of bed.

Answered: 7 Skipped: 0



Powered by SurveyMonkey

Q8: A sign of depression includes feeling a lack of energy to get out of bed.

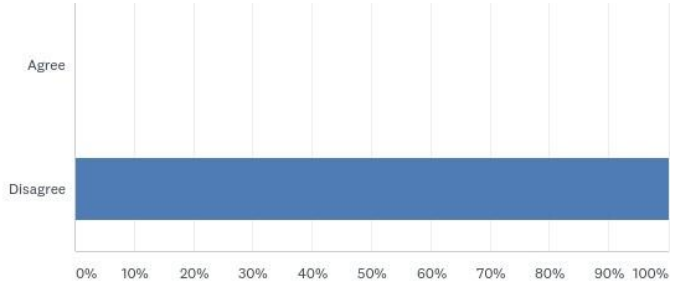
Answered: 7 Skipped: 0

ANSWER CHOICES	RESPONSES	
Agree	100.00%	7
Disagree	0.00%	0
TOTAL		7

Powered by SurveyMonkey

Q9: Most African American men are willing to take medication for depression.

Answered: 7 Skipped: 0



Powered by SurveyMonkey

Q9: Most African American men are willing to take medication for depression.

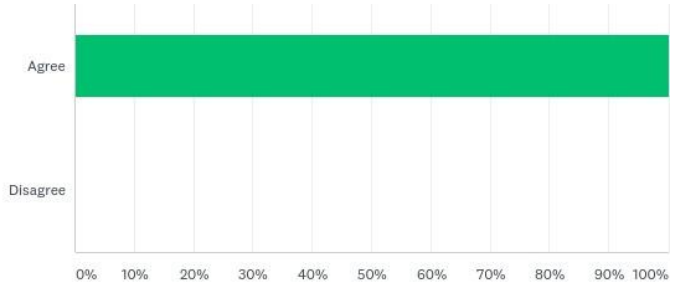
Answered: 7 Skipped: 0

ANSWER CHOICES	RESPONSES	
Agree	0.00%	0
Disagree	100.00%	7
TOTAL		7

Powered by SurveyMonkey

Q10: Many African American men would feel ashamed if anyone knew they had depression or a mental illness..

Answered: 7 Skipped: 0



Powered by SurveyMonkey

Q10: Many African American men would feel ashamed if anyone knew they had depression or a mental illness..

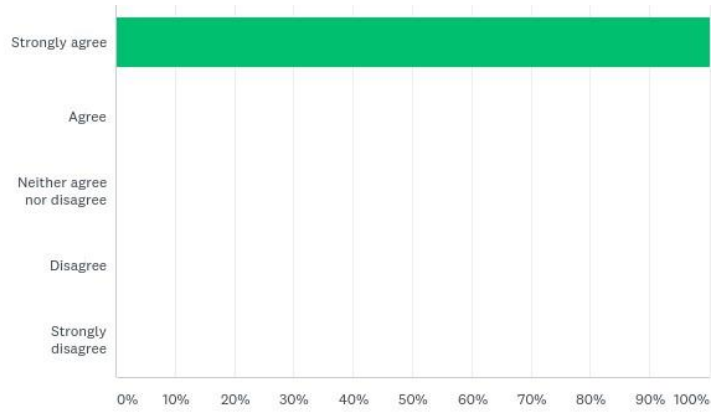
Answered: 7 Skipped: 0

ANSWER CHOICES	RESPONSES	
Agree	100.00%	7
Disagree	0.00%	0
TOTAL		7

APPENDIX 5: WEB-BASED EVALUATION

Q1: The content on depression was interesting

Answered: 8 Skipped: 0



Powered by SurveyMonkey

Q1: The content on depression was interesting

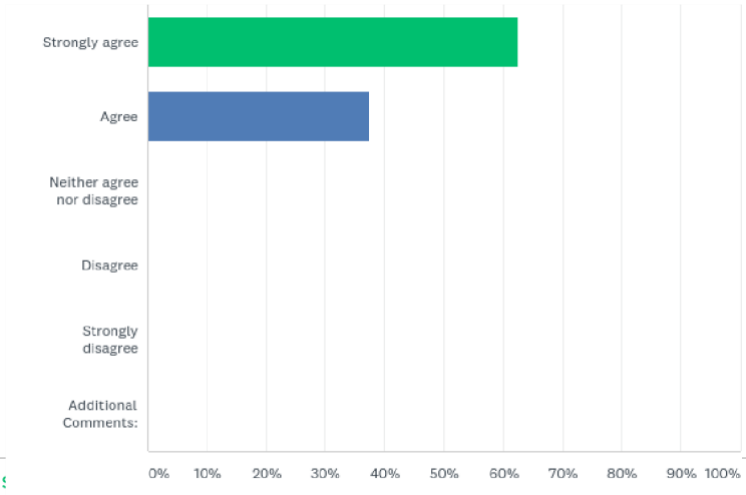
Answered: 8 Skipped: 0

ANSWER CHOICES	RESPONSES	
Strongly agree	100.00%	8
Agree	0.00%	0
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		8

Powered by SurveyMonkey

Q2: The educational session increased my knowledge about mental health

Answered: 8 Skipped: 0



Powered by

Q2: The educational session increased my knowledge about mental health

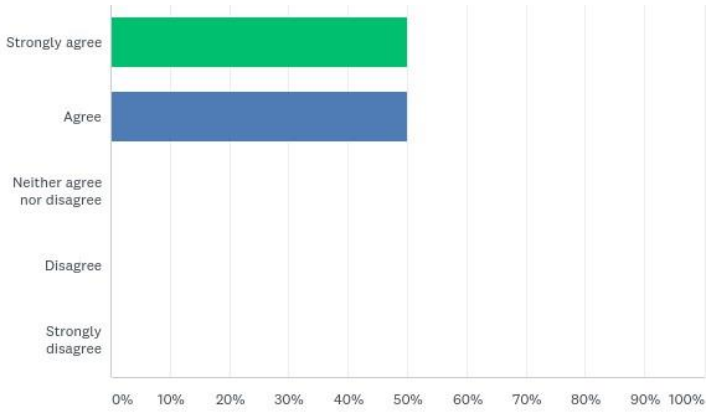
Answered: 8 Skipped: 0

ANSWER CHOICES	RESPONSES	
Strongly agree	62.50%	5
Agree	37.50%	3
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
Additional Comments:	0.00%	0
TOTAL		8

Powered by SurveyMonkey

Q3: The educational session increased my knowledge about behaviors associated with depression.

Answered: 8 Skipped: 0



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Q3: The educational session increased my knowledge about behaviors associated with depression.

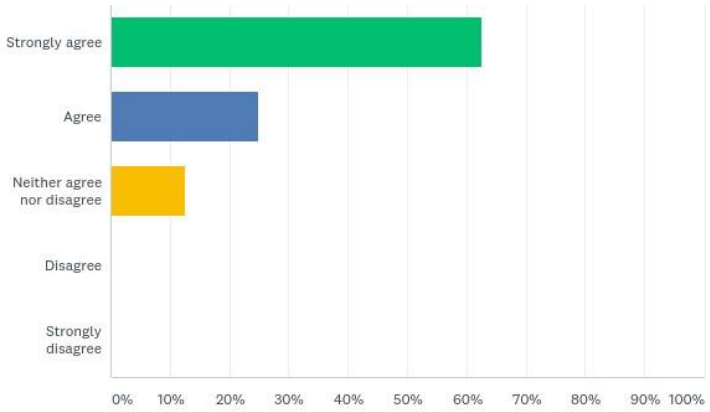
Answered: 8 Skipped: 0

ANSWER CHOICES	RESPONSES	
Strongly agree	50.00%	4
Agree	50.00%	4
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		8

Powered by SurveyMonkey

Q4: The educational session increased my knowledge about the potential effects of depression

Answered: 8 Skipped: 0



Powered by SurveyMonkey

Q4: The educational session increased my knowledge about the potential effects of depression

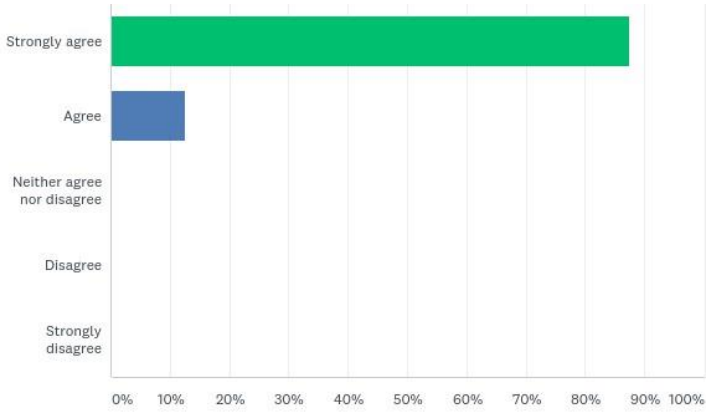
Answered: 8 Skipped: 0

ANSWER CHOICES	RESPONSES	
Strongly agree	62.50%	5
Agree	25.00%	2
Neither agree nor disagree	12.50%	1
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		8

Powered by SurveyMonkey

Q5: The education session increased my confidence in sharing about depression with my customers?

Answered: 8 Skipped: 0



Powered by SurveyMonkey

Q5: The education session increased my confidence in sharing about depression with my customers?

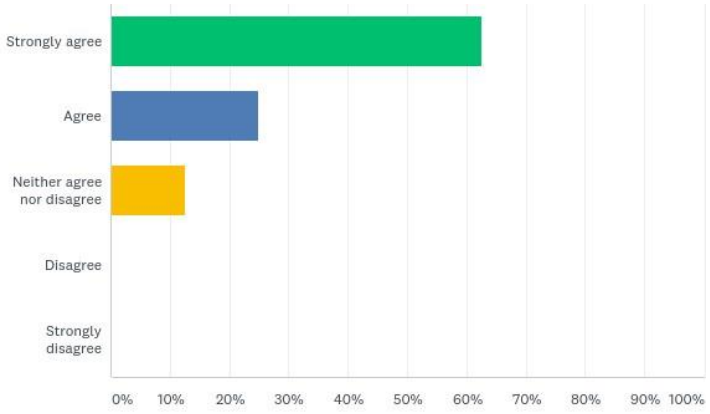
Answered: 8 Skipped: 0

ANSWER CHOICES	RESPONSES	
Strongly agree	87.50%	7
Agree	12.50%	1
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		8

Powered by SurveyMonkey

Q6: Using the rapid response code gave me a greater sense of privacy and respect

Answered: 8 Skipped: 0



Powered by SurveyMonkey

Q6: Using the rapid response code gave me a greater sense of privacy and respect

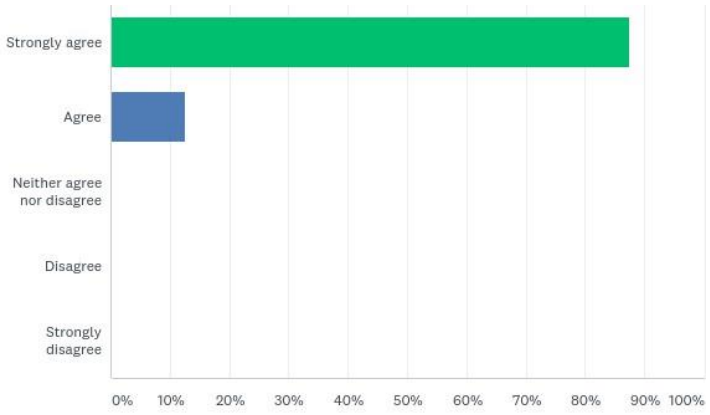
Answered: 8 Skipped: 0

ANSWER CHOICES	RESPONSES	
Strongly agree	62.50%	5
Agree	25.00%	2
Neither agree nor disagree	12.50%	1
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		8

Powered by SurveyMonkey

Q7: The session was held in a setting that was convenient

Answered: 8 Skipped: 0



Powered by SurveyMonkey

Q7: The session was held in a setting that was convenient

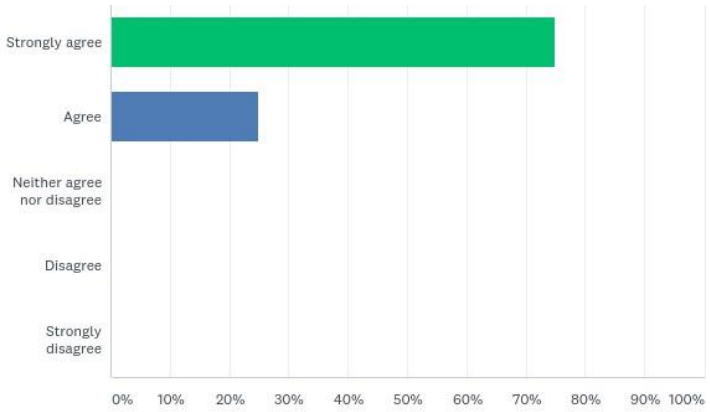
Answered: 8 Skipped: 0

ANSWER CHOICES	RESPONSES	
Strongly agree	87.50%	7
Agree	12.50%	1
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		8

Powered by SurveyMonkey

Q8: The educational content was well-organized.

Answered: 8 Skipped: 0



Powered by SurveyMonkey

Q8: The educational content was well-organized.

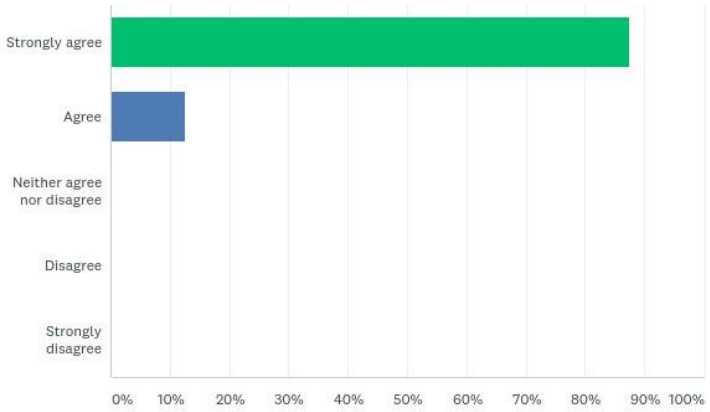
Answered: 8 Skipped: 0

ANSWER CHOICES	RESPONSES	
Strongly agree	75.00%	6
Agree	25.00%	2
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		8

Powered by SurveyMonkey

Q9: The educational materials (website) are potentially useful

Answered: 8 Skipped: 0



Powered by SurveyMonkey

Q9: The educational materials (website) are potentially useful

Answered: 8 Skipped: 0

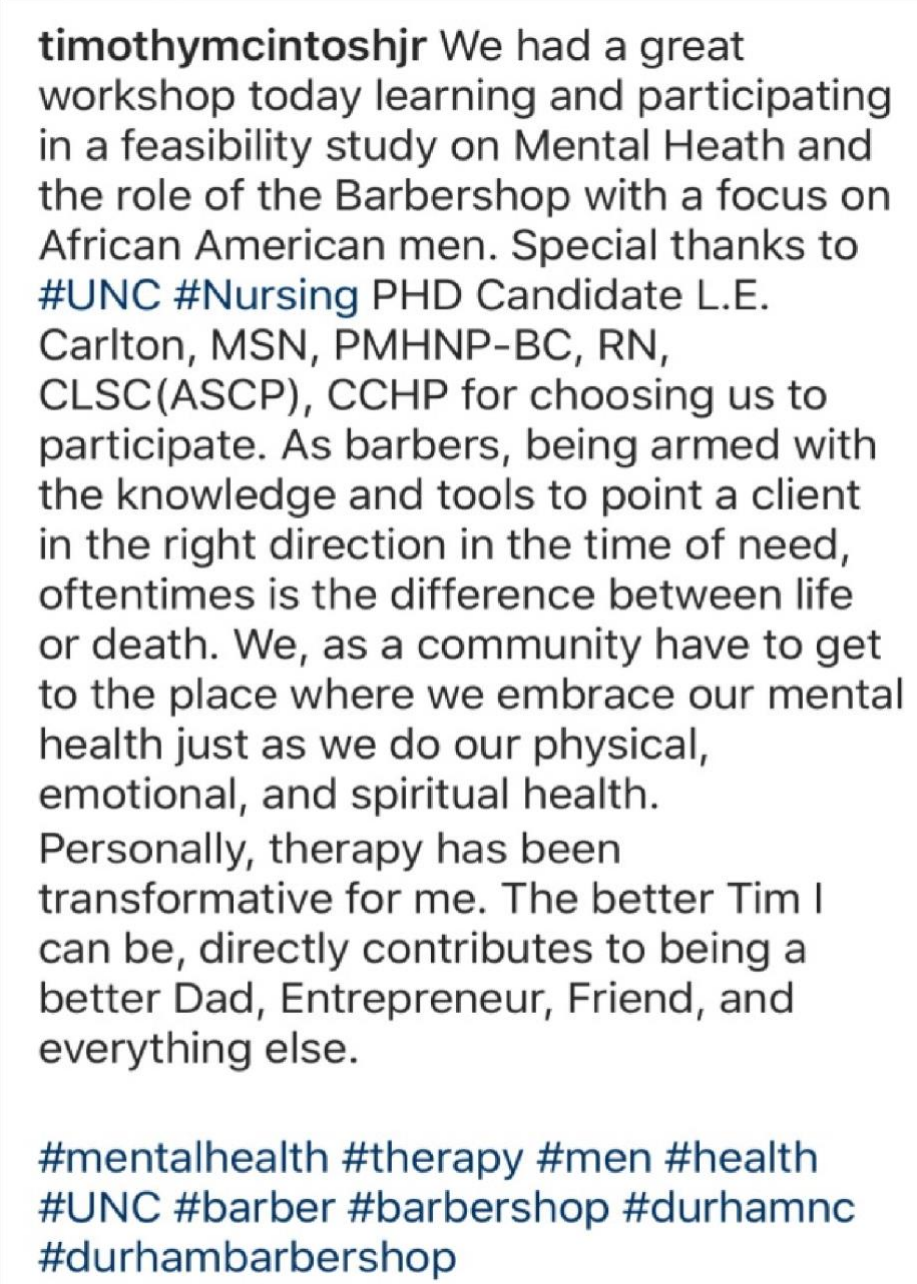
Powered by SurveyMonkey

ANSWER CHOICES	RESPONSES	
Strongly agree	87.50%	7
Agree	12.50%	1
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		8

Q10 What additional information would you like to see on the website?

	Following responses were free texted on A.D.A.A.M. web site
1	Alternatives to medication.
2	More info on discretely, electronically, sharing info with clients.
3	Was a great presentation and well prepared
4	Publication and or numbers to steer clients who could potentially need help.
5	More time for more information
6	Alternative healing methods. H

APPENDIX 6: UNEXPECTED FINDINGS



timothymcintoshjr We had a great workshop today learning and participating in a feasibility study on Mental Heath and the role of the Barbershop with a focus on African American men. Special thanks to #UNC #Nursing PHD Candidate L.E. Carlton, MSN, PMHNP-BC, RN, CLSC(ASCP), CCHP for choosing us to participate. As barbers, being armed with the knowledge and tools to point a client in the right direction in the time of need, oftentimes is the difference between life or death. We, as a community have to get to the place where we embrace our mental health just as we do our physical, emotional, and spiritual health.

Personally, therapy has been transformative for me. The better Tim I can be, directly contributes to being a better Dad, Entrepreneur, Friend, and everything else.

#mentalhealth #therapy #men #health #UNC #barber #barbershop #durhamnc #durhambarbershop

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#mentalhealth #therapy #men #health #UNC **#barber #barbershop #durhamnc #durhambarbershop**

REFERENCES

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.) Washington, DC.

Anthony, J. S., Johnson, A., & Schafer, J. (2015). African American clergy and depression: What they know, what they want to know. *Journal of Cultural Diversity*, *22*(4), 118–126.

Bailey, R.K., Blackmon, H.L., Stevens, F.L. (2009). Major depressive disorder in the African American population: meeting the challenges of stigma, misdiagnosis, and treatment disparities. *Journal of the National Medical Assocation*, *101*(11), 1084-1089.

Bates, B. R., & Harris, T. M. (2004). The Tuskegee Study of untreated syphilis and public perceptions of biomedical research: a focus group study. *Journal of the National Medical Association*, *96*(8), 1051–1064.

Bertilsson, M., Petersson, E. L., Ostlund, G., Waern, M., Hensing, G., Sallis, A., & Birkin, R. (2013). Experiences of work and sickness absence in employees with depression: an interpretative phenomenological analysis. *Journal of Occupational Rehabilitation*, *24*(3), 1705–1711. https://doi.org/10.1007/s10926-013-9481-6 [doi]

Black, H. K., Gitlin, L., & Burke, J. (2011). Context and culture: African-American elders' experiences of depression. *Mental Health, Religion & Culture*, *14*(7), 643–657. https://doi.org/10.1080/13674676.2010.505233

Blumberg, S. J., Clarke, T. C., & Blackwell, D. L. (2015). Racial and ethnic disparities in men's use of mental health treatments. *NCHS Data Brief, (206)*, 1–8.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, *32*(7), 513–531. https://doi.org/10.1037/0003-066X.32.7.513

Bryant, K., Haynes, T., Greer-Williams, N., & Hartwig, M. S. (2014). Too blessed to be stressed: a rural faith community's views of African-American males and depression. *Journal of*

Religion and Health, 53(3), 796–808. https://doi.org/10.1007/s10943-012-9672-z [doi]

Center for Disease Control and Prevention. (2016). 10 Leading causes of death by age group, Black males-United States-2013. https://www.cdc.gov/injury/wisqars/pdf/10lcid_all_deaths_by_age_group_2010-a.pdf

Eriksson, M., Ghazinour, M., & Hammarström, A. (2018). Different uses of Bronfenbrenner's ecological theory in public mental health research: What is their value for guiding public mental health policy and practice? *Social Theory & Health,* 16(4), 414-433. https://doi.org/10.1057/s41285-018-0065-6

Fraser, M., Brown, H., Homel, P., Macchia, R. J., LaRosa, J., Clare, R., … Browne, R. C. (2009). Barbers as lay health advocates--developing a prostate cancer curriculum. *Journal of the National Medical Association*, *101*(7), 690–697.

Greenberg, P. E., Fournier, A.-A., Sisitsky, T., Pike, C. T., & Kessler, R. C. (2015). The economic burden of adults with major depressive disorder in the United States (2005 and 2010). *The Journal of Clinical Psychiatry*, *76*(2), 155–162. https://doi.org/10.4088/JCP.14m09298

Hall, W. J., Chapman, M. V, Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., … Coyne-Beasley, T. (2015). Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: A systematic review. *American Journal of Public Health, 105*(12), e60-76. https://doi.org/10.2105/AJPH.2015.302903

Hammond, W. P. (2012). Taking it like a man: Masculine role norms as moderators of the racial discrimination-depressive symptoms association among African American men. *American Journal of Public Health, 102,* S232–S241. https://doi.org/10.2105/AJPH.2011.300485

Hankerson, S.H., Lee, Y. A., Brawley, D. K., Braswell, K., Wickramaratne, P. J., & Weissman,

M. M. (2015). Screening for depression in African-American churches. *American Journal of Preventive Medicine*, *49*(4), 526–533. https://doi.org/10.1016/j.amepre.2015.03.039

Hankerson, Sidney H, Suite, D., & Bailey, R. K. (2015). Treatment disparities among African American men with depression: Implications for clinical practice. *Journal of Health Care for the Poor & Underserved*, *26*(1), 21–34. https://doi.org/10.1353/hpu.2015.0012

Hood, K. B., Hart, A. J., Belgrave, F. Z., Tademy, R. H., & Jones, R. A. (2012). The role of trust in health decision making among African American men recruited from urban barbershops. *Journal of the National Medical Association*, *104*(7–8), 351–359.

Hood, S., Hall, M., Dixon, C., Jolly, D., & Linnan, L. (2018). Organizational-level recruitment of barbershops as health promotion intervention study sites: Addressing health disparities among Black men. *Health Promotion Practice*, *19*(3), 377–389. https://doi.org/10.1177/1524839917696715

Hood, S., Linnan, L., Jolly, D., Muqueeth, S., Hall, M. B., Dixon, C., & Robinson, S. (2015). Using the PRECEDE planning approach to develop a physical activity intervention for African American men who visit barbershops: Results from the FITShop study. *American Journal of Men's Health*, *9*(4), 262–273. https://doi.org/10.1177/1557988314539501

Jackson, J. S., Abelson, J. M., Berglund, P. A., Mezuk, B., Torres, M., & Zhang, R. (2011). The intersection of race, ethnicity, immigration, and cultural influences on the nature and distribution of mental disorders: An examination of major depression. In D. A. Regier, W. E. Narrow, E. A. Kuhl, D. J. Kupfer, Regier D.A., Narrow W.E., … Kupfer D.J. (Eds.) (pp. 267–285). Arlington, VA, US: American Psychiatric Publishing, Inc.

James, S. (1994). John Henryism and the health of African-Americans. *Culture, Medicine and Psychiatry*, *18*(2), 163–182.

Joe, S., Scott, M. L., & Banks, A. (2018). What works for adolescent Black males at risk of suicide: A review. *Research on Social Work Practice*, *28*(3), 340–345. https://doi.org/10.1177/1049731517702745

Kendrick, L., Anderson, N. L. R., & Moore, B. (2007). Perceptions of depression among young African American men. *Family & Community Health*, *30*(1), 63–73.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K. R., … Replication, N. C. S. (2003). The epidemiology of major depressive disorder: Results from the National Comorbidity Survey Replication (NCS-R). *Jama*, *289*(23), 3095–3105. https://doi.org/10.1001/jama.289.23.3095 [doi]

Keyes, C. L. (2009). The Black-White paradox in health: Flourishing in the face of social inequality and discrimination. *Journal of Personality*, *77*(6), 1677–1706. https://doi.org/10.1111/j.1467-6494.2009.00597.x

Latalova, K., Kamaradova, D., & Prasko, J. (2014). Perspectives on perceived stigma and selfstigma in adult male patients with depression. *Neuropsychiatric Disease and Treatment*, *10*, 1399–1405. https://doi.org/10.2147/NDT.S54081

Linnan, L A, Kim, A. E., Wasilewski, Y., Lee, A. M., Yang, J., & Solomon, F. (2001). Working with licensed cosmetologists to promote health: results from the North Carolina beauty and health pilot study. *Preventive Medicine*, *33*(6), 606–612. https://doi.org/10.1006/pmed.2001.0933

Linnan, Laura A, D'Angelo, H., & Harrington, C. B. (2014). A literature synthesis of health promotion research in salons and barbershops. *American Journal of Preventive Medicine*, *47*(1), 77–85. https://doi.org/10.1016/j.amepre.2014.02.007

Linnan, Laura A, & Ferguson, Y. O. (2007). Beauty salons: A promising health promotion setting for reaching and promoting health among African American women. *Health*

Education & Behavior, *34*(3), 517–530. https://doi.org/10.1177/1090198106295531

Linnan, Laura A, Reiter, P. L., Duffy, C., Hales, D., Ward, D. S., & Viera, A. J. (2011). Assessing and promoting physical activity in African American barbershops: Results of the FITStop pilot study. *American Journal of Men's Health*, *5*(1), 38–46. https://doi.org/10.1177/1557988309360569

Luque, J. S., Rivers, B. M., Gwede, C. K., Kambon, M., Green, B. L., & Meade, C. D. (2011). Barbershop communications on prostate cancer screening using barber health advisers. *American Journal of Men's Health*, *5*(2), 129–139. https://doi.org/10.1177/1557988310365167

Luque, J. S., Rivers, B. M., Kambon, M., Brookins, R., Green, B. L., & Meade, C. D. (2010). Barbers against prostate cancer: A feasibility study for training barbers to deliver prostate cancer education in an urban African American community. *Journal of Cancer Education: The Official Journal of the American Association for Cancer Education*, *25*(1), 96–100. https://doi.org/10.1007/s13187-009-0021-1

Luque, J. S., Ross, L., & Gwede, C. K. (2014). Qualitative systematic review of barber administered health education, promotion, screening and outreach programs in African-American communities. *Journal of Community Health*, *39*(1), 181–190. https://doi.org/10.1007/s10900-013-9744-3

Matthews, D. D., Hammond, W. P., Nuru-Jeter, A., Cole-Lewis, Y., & Melvin, T. (2013). Racial discrimination and depressive symptoms among African-American men: The mediating and moderating roles of masculine self-reliance and John Henryism. *Psychology of Men & Masculinity*, *14*(1), 35–46. https://doi.org/10.1037/a0028436

McIntyre, R. S., Cha, D. S., Soczynska, J. K., Woldeyohannes, H. O., Gallaugher, L. A., Kudlow, P., … Baskaran, A. (2013). Cognitive deficits and functional outcomes in major

depressive disorder: Determinants, substrates, and treatment interventions. *Depression and Anxiety, 30*(6), 515–527. https://doi.org/10.1002/da.22063

Mezuk, B., Abdou, C. M., Hudson, D., Kershaw, K. N., Rafferty, J. A., Lee, H., & Jackson, J. S. (2013). "White Box" epidemiology and the social neuroscience of health behaviors: The Environmental Affordances Model. *Society and Mental Health, 3*(2),79-95. 10.1177/2156869313480892. https://doi.org/10.1177/2156869313480892

Mezuk, B., Rafferty, J. A., Kershaw, K. N., Hudson, D., Abdou, C. M., Lee, H., … Jackson, J. S. (2010). Reconsidering the role of social disadvantage in physical and mental health: Stressful life events, health behaviors, race, and depression. *American Journal of Epidemiology, 172*(11), 1238–1249. https://doi.org/10.1093/aje/kwq283

Moore, N., Wright, M., Gipson, J., Jordan, G., Harsh, M., Reed, D., … Murphy, A. (2016). A Survey of African American men in Chicago barbershops: Implications for the effectiveness of the barbershop model in the health promotion of African American men. *Journal of Community Health, 41*(4), 772–779. https://doi.org/10.1007/s10900-016-0152-3

Murphy, A. B., Moore, N. J., Wright, M., Gipson, J., Keeter, M., Cornelious, T., … Murray, M. (2017). Alternative locales for the health promotion of African American men: A survey of African American men in Chicago barbershops. *Journal of Community Health, 42*(1), 139–146. https://doi.org/10.1007/s10900-016-0240-4

Payne, J. S. (2009). Variations in pastors' perceptions of the etiology of depression by race and religious affiliation. *Community Mental Health Journal, 45*(5), 355–365. https://doi.org/10.1007/s10597-009-9210-y

Payne, J. S. (2014). The influence of secular and theological education on pastors' depression intervention decisions. *Journal of Religion and Health, 53*(5), 1398–1413.

https://doi.org/10.1007/s10943-013-9756-4 [doi]

Penner, L. A., Dovidio, J. F., West, T. V, Gaertner, S. L., Albrecht, T. L., Dailey, R. K., & Markova, T. (2010). Aversive racism and medical interactions with Black patients: A field study. *Journal of Experimental Social Psychology*, *46*(2), 436–440. https://doi.org/10.1016/j.jesp.2009.11.004

Plowden, K. O., Adams, L. T., & Wiley, D. (2016). Black and blue: Depression and African American men. *Archives of Psychiatric Nursing*, *30*(5), 630–635. https://doi.org/10.1016/j.apnu.2016.04.007

Powell, W., Richmond, J., Mohottige, D., Yen, I., Joslyn, A., & Corbie-Smith, G. (2019). Medical mistrust, racism, and delays in preventive health screening among African-American men. *Behavioral Medicine*, *45*(2), 102–117. https://doi.org/10.1080/08964289.2019.1585327

Probst, J. C., Laditka, S. B., Moore, C. G., Harun, N., & Powell, M. P. (2007). Race and ethnicity differences in reporting of depressive symptoms. *Administration and Policy in Mental Health*, *34*(6), 519–529. https://doi.org/10.1007/s10488-007-0136-9

Rader, F., Elashoff, R. M., Niknezhad, S., & Victor, R. G. (2013). Differential treatment of hypertension by primary care providers and hypertension specialists in a barber-based intervention trial to control hypertension in Black men. *American Journal of Cardiology*, *112*(9), 1421–1426. https://doi.org/10.1016/j.amjcard.2013.07.004

Rich, J. (2000). The health of African American men. *ANNALS of the American Academy of Political and Social Science*, *569*(1), 149–159. https://doi.org/10.1177%2F000271620056900111

Rochlen, A. B., Whilde, M. R., & Hoyer, W. D. (2005). The real men. Real depression campaign: Overview, theoretical implications, and research considerations. *Psychology of*

Men & Masculinity, *6*(3), 186–194. https://doi.org/10.1037/1524-9220.6.3.186

Rosa, E. M., & Tudge, J. (2013). Urie Bronfenbrenner's theory of human development: Its evolution from ecology to bioecology. *Journal of Family Theory & Review*, *5*(4), 243–258. https://doi.org/10.1111/jftr.12022

Sirey, J. A., Franklin, A. J., McKenzie, S. E., Ghosh, S., & Raue, P. J. (2014). Race, stigma, and mental health referrals among clients of aging services who screened positive for depression. *Psychiatric Services*, *65*(4), 537–540. https://doi.org/10.1176/appi.ps.201200530

Suite, D. H., Bril, R. La, Primm, A., & Harrison-Ross, P. (2007). Beyond misdiagnosis, misunderstanding and mistrust: relevance of the historical perspective in the medical and mental health treatment of people of color. *Journal of the National Medical Association*, *99*(8), 879–885.

Thomas, A., Hammond, W. P., & Kohn-Wood, L. P. (2015). Chill, be cool man: African American men, identity, coping, and aggressive ideation. *Cultural Diversity & Ethnic Minority Psychology*, *21*(3), 369–379. https://doi.org/10.1037/a0037545

Valkanova, V., Ebmeier, K. P., & Allan, C. L. (2013). CRP, IL-6 and depression: A systematic review and meta-analysis of longitudinal studies. *Journal of Affective Disorders*, *150*(3), 736–744. https://doi.org/10.1016/j.jad.2013.06.004

Victor, R. G., Blyler, C., & Elashoff, R. M. (2018, July). A trial of blood-pressure reduction in Black barbershops. *The New England Journal of Medicine*.379(2),200-201 United States. https://doi.org/10.1056/NEJMc1806026

Victor, R. G., Blyler, C., Elashoff, R. M., Lynch, K., Li, N., Blyler, C., … Leonard, D. (2018). A barber-based intervention for hypertension in African American men: Design of a group randomized trial. *The New England Journal of Medicine*, *379*(1), 30–36.

https://doi.org/10.1056/NEJMc1806026

Victor, R. G., Ravenell, J. E., Freeman, A., Bhat, D. G., Storm, J. S., Shafiq, M., … Leonard, D. (2009). A barber-based intervention for hypertension in African American men: Design of a group randomized trial. *American Heart Journal*, *157*(1), 30–36. https://doi.org/10.1016/j.ahj.2008.08.018

Victor, R. G., Ravenell, J. E., Freeman, A., Leonard, D., Bhat, D. G., Shafiq, M., … Haley, R. W. (2011). Effectiveness of a barber-based intervention for improving hypertension control in black men: The BARBER-1 study: A cluster randomized trial. *Archives of Internal Medicine*, *171*(4), 342–350. https://doi.org/10.1001/archinternmed.2010.390

Vogel, D. L., Heimerdinger-Edwards, S. R., Hammer, J. H., & Hubbard, A. (2011). "Boys don't cry": Examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds. *Journal of Counseling Psychology*, *58*(3), 368–382. https://doi.org/10.1037/a0023688

Walker, R. L., Salami, T. K., Carter, S. E., & Flowers, K. (2014). Perceived racism and suicide ideation: Mediating role of depression but moderating role of religiosity among African American adults. *Suicide & Life-Threatening Behavior*, *44*(5), 548–559. https://doi.org/10.1111/sltb.12089

Wang, A. (2015). African American mental health: National alliance on mental illness.

Ward, E., & Mengesha, M. (2013). Depression in African American men: A review of what we know and where we need to go from here. *The American Journal of Orthopsychiatry*, *83*(2), 386–397. https://doi.org/10.1111/ajop.12015

Wayne, R., Katherine, F., Karen, F., Alan, G., Kurt, G., Nancy, H., … Yuling, H. (2008). Heart disease and stroke statistics—2008 Update. *Circulation*, *117*(4), e25–e146.

Weber, S. R., & Pargament, K. I. (2014). The role of religion and spirituality in mental health.

Current Opinion in Psychiatry, *27*(5), 358–363.

World Health Organization. (2018). Depression. Retrieved from https://www.who.int/newsroom/fact-sheets/detail/depression